MARYLAND DEPARTMENT OF HUMAN RESOURCES
FAMILY INVESTMENT ADMINISTRATION
APPLICATION FOR ASSISTANCE FOR ONE PERSON

Date Signed Application Received in Local Department **MUST BE DATE STAMPED**

PLEASE PRINT ALL ANSWERS

☐**I wish to apply for:** ☐ Cash Assistance ☐Medical Assistance ☐ Food Supplement Program (formerly food stamps) ☐Other, list: _____	☐**I am currently receiving:** ☐Cash Assistance ☐Medical Assistance: ID#_____☐ Food Supplement Program (formerly food stamps) ☐ Other, list:_____	Do you have unpaid medical bills in the last 3 months? ☐YES ☐NO

1. IDENTIFYING INFORMATION

Last Name	First Name	Middle Name	Jr. III, etc.	Maiden/Other Name

What language do you speak?	**Do you need an interpreter? ☐YES ☐NO**
Are you visually impaired ☐YES ☐NO	**Are you hearing impaired? ☐YES ☐NO**

2. ADDRESS — Where do you live?

Number Street	Apt No.	Floor No.	Telephone Number
City	State	Zip Code + 4	Number where you can be reached during the day

3. MAILING ADDRESS *(IF DIFFERENT)*

Number Street	Apt No.	Floor No.	Telephone Number

P.O. Box	City	State	Zip Code + 4

If you are applying for the Food Supplement Program (FSP) you can complete all of the form and give it to us now. You may also fill in your name, address, sign this page and give it to us. You can then finish the rest of the application at home and bring or mail it back to the office. Your Food Supplement benefit is based on the date you sign this application and give it to the department of social services.

You may get Food Supplement benefits right away if you meet one of the following conditions:

- Your household's monthly rent or mortgage and utilities are more than your household's income and resources.
- Your household's gross monthly income is less than $150, and your resources, such as bank accounts, are $100 or less.
- Your household is a migrant or seasonal farm worker household.

If you qualify to get Food Supplement benefits right away, **you will receive** them within 7 days from the date you sign the form. You may not get expedited Food Supplement benefits, if eligible, until we get a completed application form and interview you.

YOUR SIGNATURE	**DATE**

4. EXPEDITED SERVICES (CUSTOMERS SHOULD NOT WRITE IN THIS AREA – FOR AGENCY USE ONLY)

Applicants who meet the standards below are eligible to receive FSP benefits within 7 days. Customers must be interviewed, either in person or by telephone, in order to determine eligibility for expedited service. The application must be complete, signed, and identity verified before expedited benefits can be issued.

1. Is the total household income this month, before deductions, less than $150 AND household cash/savings $100 or less? □ **Yes** □ **No**
   Estimated self-reported income for this month = $_____ Household's monthly rent or mortgage amount = $_____
   Household cash and savings for all members = $_____ Appropriate utility standard (SUA, LUA or actual) = $_____
   A. Total income and liquid resources = $_____ **B. Total shelter costs** = $_____
2. Is the total amount for **B. (Total shelter costs)** greater than the total for **A. (Total income and liquid resources)**? □ **Yes** □ **No**
3. Are the household members destitute migrant or seasonal farm workers whose cash and savings are $100 or less? □ **Yes** □ **No**
   If the answer to any of the above questions is yes, this household is potentially eligible for expedited FSP benefits
4. If there is another reason why this household should NOT be expedited, list it here: _____

I certify that I screened this applicant for expedited Food Supplement Program benefits and determined that the household □ was □ was not eligible for expedited issuance at this time.

Signature of Case Manager	Date

FOR WORKER USE ONLY	LDSS Office	Programs Applied For / Receiving	Assistance Unit ID's
	Case Manager's Name		**Client ID**
	Application/Redetermination Date		

5. AUTHORIZED REPRESENTATIVE *(IF DESIRED)*

First Name	Middle Name	Last Name	Jr., III, etc.

Number Street	City	State	Zip Code + 4

Telephone Number	Relationship to you

Check what you want the representative to do:

☐Complete interview for you ☐ Cash your check ☐ Receive your notices
☐Sign your application ☐ Cash your Food benefits ☐ Receive your Medical Assistance Card

6. INDIVIDUAL INFORMATION Complete the section below.

Last Name	First Name	Middle Name	Jr.,III etc.

Maiden/Other Name	Social Security Number	List Additional Social Security Number	Date of Birth

Sex ☐Male ☐Female	Ethnicity* (see below)	Race* (see below)	Marital Status

Resident of Maryland ☐YES ☐NO	Due date if pregnant	Number of babies expected?	Receiving Prenatal Care? ☐YES ☐NO

Receiving benefits in another state:
Public Assistance? ☐YES ☐NO Food benefits? ☐YES ☐NO Medical Assistance? ☐YES ☐NO

U.S. Citizen? ☐YES ☐NO	Student? ☐YES ☐NO	On Strike? ☐YES ☐NO	Disabled or Incapacitated? ☐YES ☐NO	Medical Insurance? ☐YES ☐NO	Medicare Part A ☐YES ☐NO	Medicare#

7. MIGRANT WORKER

Are you a migrant worker?
☐YES ☐NO

8. BOARDER If you are a boarder, fill in this sections:

Number of Meals per Day	Cost of Meals per Month $

8 IMMIGRATION STATUS — If you are not a United States citizen, fill in this section

INS Status	Newly Legalized Status Date	Sponsored Alien ☐YES ☐NO	Country of Origin

US Entry Date	INS Number	**Maryland uses the Systematic Alien Verification and Eligibility or SAVE system through the United States Citizenship and Immigration Service (USCIS) formerly known as Immigration and Naturalization Service (INS) to verify the alien status of all applicant and recipient non-citizen households. Information received from USCIS may affect your household's eligibility and benefit amount.**

9. SCHOOL — If you are in school, fill in this section:

Student Status ☐Full-time ☐Half-time ☐Less than half-time	Educational Level ☐Elementary ☐ College ☐Secondary ☐ Other, List:_____	Highest Grade Completed Expected Graduation Date (*If in high school*)

School Name	School Number

School Address	City	State	Zip Code + 4

10. DISABILITY — If you are disabled or incapacitated, what is the disability?

*****Use the codes below to complete the Race and Ethnicity blocks. Enter each code that applies, using at least one code for each person. **Ethnicity Codes:** 1= Hispanic or Latino, 2=Not Hispanic/Latino. **Race Codes: You can choose one or more race code -** 1=American Indian/Alaskan Native, 2=Asian, 3=Black/African American, 4=Native Hawaiian/Pacific Islander, 5=White

Note: You do not have to give information about your race or ethnicity. If you do, it will help show how we obey the Federal Civil Rights Law. We will not use this information to decide if you are eligible. If you do not give us your race, it will not affect your application. The case manager will enter a race code for statistical purposes only. Title VI of the Civil Rights Act of 1964 allows us to ask for this information.

11. MEDICAL INSURANCE — If you have medical insurance, fill in this section:			
Policy Number	Group Number		Policy Holder Name
Relationship to Policy Holder			
POLICY HOLDER ADDRESS			
Number Street			
City	State	Zip Code + 4	Telephone Number
INSURANCE COMPANY			
Insurance Company Name			
Number Street			
City	State	Zip Code + 4	Telephone Number
UNION			
Union Name			Union Local Number
Number Street			
City	State	Zip Code + 4	Telephone Number

12. VETERAN INFORMATION — If you are a veteran or a disabled widow or widower, or a disabled child of a deceased veteran, fill in this section:			
Veteran's Name	Relationship to Veteran	Veteran's Status	Military Service Number

13. MEDICAL EXPENSE

If you are 60 or older, blind or disabled and applying for or receiving Food Supplement Program benefits, do you have medical bills that you must pay? ☐YES ☐NO *If Yes, bring in your bills.*

14. LIQUID ASSETS — Complete for assets as of the 1st day of the month. Check Yes or No for each ASSET TYPE

ASSET TYPE	CHECK ONE	OWNER	AMOUNT Balance/value	ACCOUNT NUMBER	FDIC NUMBER	INSTITUTION
Cash on Hand	☐YES ☐NO		$	N/A	N/A	N/A
Checking Accounts	☐YES ☐NO		$			
Savings Accounts	☐YES ☐NO		$			
Credit Union Accounts	☐YES ☐NO		$			
Trust Funds	☐YES ☐NO		$			
IRA or Keogh Accounts	☐YES ☐NO		$			
Stocks, bonds, Certificates, Money Market Funds, mutual funds, treasury or Other Notes	☐YES ☐NO		$			
Annuities:	☐YES ☐NO		$			
Other, List:	☐YES ☐NO		$			
Other, List	☐YES ☐NO		$			
Other, List	☐YES ☐NO		$			

15. LIFE INSURANCE AND FUNERAL PLANS — If you have any life insurance or pre-paid burial plans or funds, fill in this section. List all policies and plans no matter who pays for them.

NAME OF PERSON WHO PAYS	ORIGINAL FACE VALUE OR VALUE OF PLAN	CURRENT CASH VALUE	POLICY NUMBER OR ACCOUNT NUMBER	LIFE INSURANCE OR BURIAL PLAN	COMPANY, FUNERAL HOME OR BANK NAME
	$	$			
	$	$			

16. REAL PROPERTY — If you own property other than where you live, fill in this section. Include burial plots.

Number Street	City	State	Zip Code + 4

How Used?	Current Fair Market	Amount Owed Now	Trying to Sell ☐YES ☐NO

Number Street	City	State	Zip Code + 4

How Used?	Current Fair Market	Amount Owed Now	Trying to Sell ☐YES ☐NO

17. OTHER ASSETS — If you own other assets not listed, such as antiques, boat, recreational vehicle, coin collections, furs, jewelry, livestock, or stamp collections, fill in this sections:

ASSET TYPE	CURRENT FAIR MARKET VALUE	AMOUNT OWED
	$	$
	$	$

18. POTENTIAL ASSET OR INCOME — If you are expecting to receive an accident settlement, trust fund, inheritance or other money or property, fill in this section.

Type	Lawyer Name
Explanation	Lawyer Telephone

19. TRANSFER OF ASSETS — if you sold, traded or gave any property, motor vehicles, stocks, bonds, cash or other assets in the past 3 years (5 years for a trust), fill in this sections:

Transfer Date	Who Received the Asset?	Type of Assets

Fair Market Value When Transferred	Amount Received	Reason for Transfer

20. INCOME FROM WORKING — If you are working now, fill in this section. If not, list the last job held. Include full-time, part-time or temporary work or self-employment, such as owning a business, roomer or boarder income, babysitting, home demonstrations, cleaning houses, odd jobs, etc.

NAME OF EMPLOYER (INCLUDE ADDRESS AND PHONE NUMBER)	Rate of Pay	Number of Hours Worked	Amount Per Pay Period	How often Received?	if Job Ended, Date and amount of Last Pay

21. OTHER INCOME AND BENEFITS — Check if you are receiving, have applied for or have been denied any of the following:

TYPE OF BENEFIT	RECEIVING BENEFITS	AMOUNT	APPLICATION STATUS	APPLICATION OR DENIAL DATE
Alimony	☐YES ☐NO	$	☐Applied for ☐Denied	
Child Support	☐YES ☐NO	$	☐Applied for ☐Denied	
Social Security Claim #:	☐YES ☐NO	$	☐Applied for ☐Denied	
SSI Claim #:	☐YES ☐NO	$	☐Applied for ☐Denied	
Railroad Retirement Benefits Claim#:	☐YES ☐NO	$	☐Applied for ☐Denied	
Veteran's Pension/Benefits	☐YES ☐NO	$	☐Applied for ☐Denied	
Unemployement Benefits	☐YES ☐NO	$	☐Applied for ☐Denied	
Worker's Compensation	☐YES ☐NO	$	☐Applied for ☐Denied	
Pension or Retirement	☐YES ☐NO	$	☐Applied for ☐Denied	
Disablility/Sick/Maternity Benefits	☐YES ☐NO	$	☐Applied for ☐Denied	
Union Benefits	☐YES ☐NO	$	☐Applied for ☐Denied	
Military Allotment	☐YES ☐NO	$	☐Applied for ☐Denied	
Money from Friends or Relatives (loans & other)	☐YES ☐NO	$	☐Applied for ☐Denied	
Money from Rental income	☐YES ☐NO	$	☐Applied for ☐Denied	
Black Lung Benefits	☐YES ☐NO	$	☐Applied for ☐Denied	
Lump Sum Amounts	☐YES ☐NO	$	☐Applied for ☐Denied	
Civil Service Annuity	☐YES ☐NO	$	☐Applied for ☐Denied	
Public Assistance/State Disability Benefits from Another State	☐YES ☐NO	$	☐Applied for ☐Denied	
Interest or Dividends from Stocks, Bonds, Savings, or Other Investments	☐YES ☐NO	$	☐Applied for ☐Denied	
Other Income (*not listed above*) Specify _____	☐YES ☐NO	$	☐Applied for ☐Denied	
Other Income (*not listed above*) Specify _____	☐YES ☐NO	$	☐Applied for ☐Denied	

22. SHELTER COSTS — Are you paying for any of the following? Complete only if you are applying for Food Supplement benefits

Expenses	**Check One**	**Amount**	**How Often Paid?**	**Who Pays?**	**Expenses**	**Check One**	**Amount**	**How Often Paid?**	**Who Pays?**
Rent	☐YES☐NO	$			Sewer	☐YES☐NO	$		
Mortgage	☐YES☐NO	$			Garbage	☐YES☐NO	$		
Electric	☐YES☐NO	$			Coop/ Condo Fee	☐YES☐NO	$		
Oil	☐YES☐NO	$			Homeowner Insurance (if not included in mortgage)	☐YES☐NO	$		
Gas	☐YES☐NO	$							
Property Taxes	☐YES☐NO	$			Other Utility Cost, list	☐YES☐NO	$		
Telephone	☐YES☐NO	$			Other Utility Cost, list	☐YES☐NO	$		
Water	☐YES☐NO	$			Other Utility Cost, list	☐YES☐NO	$		

23. SHELTER COSTS — (continued) Are you paying for any of the following? Complete only if you are applying for Food Supplement benefits

Do you live in: □ Public Housing □ Section 8 Housing □ FMHA 515 Housing □ Private Housing

Is heat included in your rent? □ Yes □ No Do you pay an electric bill for lights or cooking? □ Yes □ No

If heat is not included in the rent, what is your source of heat? _____ Do you pay for air conditioning? □ Yes □ No

Have you received Energy Assistance at your current address within the past 12 months? □ Yes □ No

Does someone help you with your utility costs? □ Yes □ No If yes, who?_____

Are you sharing any of the shelter costs listed above? □ Yes □ No If yes, with whom? _____

Your share? _____

TYPE OF EXPENSES SHARED	WITH WHOM	TOTAL AMOUNT OF SHARED EXPENSES	AMOUNT OF YOUR SHARE
		$	$
		$	$

24. ADDITIONAL INFORMATION

25. HOUSEHOLD'S DECLARATION INQUIRY – Complete if you are applying for Temporary Cash Assistance or Food Supplement benefits

1. Has anyone in your household ever been convicted of a felony committed on or after August 22,1996 that involved drugs?
   □ YES □ NO If yes, who? _____
2. Is anyone in your household currently violating parole or probation or fleeing from the police or the courts?
   □ YES □ NO If yes, who? _____
3. Has anyone in your household been convicted since August 22, 1996 in a Federal or State Court for not telling the truth about where they lived or their identity in order to receive food supplement benefits or cash assistance from more than one place in the same month?
   □ YES □ NO If yes, who? _____
4. Has a court convicted any member of your household for trading or trafficking food supplement benefits of $500 or more?
   □ YES □ NO If yes, who? _____
5. Is anyone in your household receiving benefits under another identity or as a member of another household or in another State?
   □ YES □ NO If yes, who?_____

RIGHTS AND RESPONSIBILITIES

The Family Investment Administration is committed to providing access, and reasonable accommodation in its services, programs, activities, education and employment for individuals with disabilities. If you need assistance or need to request a reasonable accommodation, please contact your case manager or call 1-800-332-6347.

RIGHT TO WRITTEN NOTICE – We must always give you a written notice explaining your benefits when we approve your case. We must always give you written notice when we change your benefits, deny or close your case. You have 90 days from the notice date to ask for a hearing. If you ask for a hearing within 10 days, you may be able to keep getting benefits while you wait for the hearing.

RIGHT TO APPEAL – Ask for a hearing if you disagree with the Department's decision. Your case manager can help you write your appeal. At the hearing, you can speak for yourself or bring a lawyer, friend or relative to speak for you.

EQUAL RIGHTS – This institution is prohibited from discriminating on the bases of race, color, national origin, disability, age, sex and in some cases religion and political beliefs.

The U.S. Department of Agriculture (USDA also prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program or protected genetic information in employment or in any program or activity conducted or funded by the Department.(Not all bases apply to all programs and or employment activities.) USDA and HHS are equal opportunity providers and employers.

If you think we have discriminated against you contact USDA or HHS. To contact USDA for the Food Supplement Program complete the **USDA Program Discrimination Complaint Form found on-line at www.ascr.usda.gov/complaint_filing_cust.html** , or write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at USDA, Director, Office of Adjudication 1400 Independence Avenue SW, Washington, DC 20250-9410. You may fax your complaint to 202-690-7442 or e-mail it to program **intake@usda.gov.** Individuals who are deaf, hard of hearing or have speech disabilities are TDD users may contact USDA through local relay or the Federal Relay at 1-800-877-8339 (TDD) or 1-866-377-8642 (relay voice users) or 800-845-6136 or Spanish.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Ave. S.W. Washington, D.C.A 20201 or call 202-619-0403 (voice) or 800-537-7697 (TTY).

If you need this information in a different format (large print, audiotape, etc.), contact the USDA's TARGET Center at 202-720-2600 (Voice or TDD). If you need information about this program, activity or facility in a language other than English, contact the Department of Social Services or Department of Human Resources at 1(800)332-6347. For any other information dealing with Food Supplement Program issues, persons should either contact the USDA Supplemental Nutrition Assistance Program (SNAP) Hotline at 800-221-5689, which is also in Spanish or call the State Information /Hotline Numbers (click www.fns.gov/snap/contact_info/hotlines.htm.

RIGHTS AND RESPONSIBILITIES

RIGHT TO PRIVACY – You are giving personal information in the application. We use the information to see if you are eligible for benefits. If you do not give the information, we may deny your application. You have a right to review, change, or correct any information. We will not show your information or give it to others unless you give us permission or federal and state law allows us to do so.

RIGHT TO CLAIM GOOD CAUSE – If you want Temporary Cash Assistance (TCA), you must help the Department get child support. You may not have to help if it puts you or your family in danger.

RIGHT TO REFUSE HELP – You do not have to accept help from a religious organization if it is against your religious beliefs.

RIGHT TO TIMELY APPLICATION PROCESSING – If you are eligible for expedited Food Supplement Program benefits we must give you your benefits within 7 days. For the regular Food Supplement Program and other programs, except for certain Medical Assistance programs, we must process your application within 30 days. There are times when there is a delay in processing. If there is a delay, we will send you a letter to tell you why there is delay in processing your application. If you are incarcerated or in another such institution and file an application for Food Supplement benefits or cash assistance, you may not receive FSP or cash benefits until you are released. The filing date of your application for assistance will be the date of your release from the institution, if it is less than 30 days from the date your signed application was received in the Local Department of Social Services (LDSS). FSP benefits are issued from the date of your release based upon your application date.

Authorization to Receive Family Planning Information

If you want information, you can ask your case manager for a Family Planning Guide. You may also contact:

- 1-800-546-8900 if you need help in finding a provider for birth control or arranging prenatal care, or
- The Center for Maternal and Child Health at 410-767-6713 www.fha.state.md.us/mch

YOU HAVE THE FOLLOWING RESPONSIBILITIES

PROVIDE INFORMATION – You must give true and complete information. You may need to give us proof of this information. We will keep this information private. Any delay in providing proof may result in your case being delayed or denied.

Collecting application information, including the social security number of each household member, is authorized under the Food and Nutrition Act of 2008, U.S.C.2011-2036, Social Security Act §1137(f) and 42 U.S.C. §1320b-7(d). We use the information to find out if your household is eligible. We check this information by matching computer programs.

We also use the information to see if you meet program rules. We may contact your employer, bank or other party. We may also contact local, state or federal agencies to make sure the information is correct. We can give your information to other federal or State agencies for official use and to law enforcement officers who need it to find persons fleeing to avoid the law.

If you get too much in benefits:

- You may have to repay the money for the benefits, and
- We may give the application information, including social security numbers, to federal or state agencies, as well as private claims collections agencies, for action.

Giving information is voluntary. If you do not give us information such as social security numbers for everyone who wants help, we may deny benefits for each person who does not give a social security number. If you do not have a social security number, we will help you get one.

RIGHTS AND RESPONSIBILITIES

REPORT CHANGES - You must report all changes within ten days unless you are part of the Food Supplement Program simplified reporting group and are not receiving Cash Assistance or Medical Assistance. If you want to know if you are part of this group, ask your case manager. You may tell us about any changes in person, by telephone, or by mail to the Department.

Warning – We may deny, lower or stop your benefits if you give us wrong information or do not report changes. A judge may fine and/or imprison you if you deliberately give wrong information or do not report changes.

AUTHORIZED REPRESENTATIVES – In most instances, if your authorized representative gives us wrong information, you will have to pay back any amount you are overpaid.
If your authorized representative knowingly gives us the wrong information or does not use your benefits properly, we may disqualify the person from being an authorized representative.
If a drug and alcohol treatment center or a group living arrangement acts as your authorized representative for your food benefits and they willfully give us wrong information about your situation, we may prosecute the person under applicable State or Federal law.

TCA and FOOD SUPPLEMENT PROGRAM PENALTIES

Do not:

- Give false information or withhold information to get or continue to get TCA and/or FSP benefits.
- Trade or sell TCA or FSP benefits, or electronic benefit cards.
- Use TCA and FSP or electronic benefit cards to buy items not allowed, such as alcohol and tobacco or to pay on credit accounts.
- Use someone else's TCA or FSP benefits.
- Use someone else's Electronic Benefits Card without authorization.
- Use your EBT card containing TCA benefits in a liquor store, adult entertainment venue such as a strip club or in a gambling establishment such as a casino.

Your FSP benefits will not increase if your cash assistance is reduced or closed because you did not follow the rules.

If a household member deliberately breaks the rules, we may bar the person from the TCA or FSP.

- We may bar this person for **one year** after the first violation.

- We may bar this person for **two years**:
  * After the second violation, or
  * After the first time a court finds this person guilty of buying illegal drugs with TCA or Food Supplement Program benefits.

- We may bar this person **permanently**:
  * After the third violation, or
  * After the second time a court finds a person guilty of buying illegal drugs with TCA or FSP benefits, or
  * After the first time a court finds this person guilty of buying guns, bullets, or explosives, with TCA or FSP benefits.
  * After a court finds this person guilty of trafficking TCA or FSP benefits of $500 or more.

We may bar this person for ten years if found guilty of making a false statement about the person's identity in order to receive multiple benefits at the same time.

- **A judge can also fine this person up to $250,000, imprison the person for up to 20 years, or both. A judge can also bar this person for an additional 18 months. The person may also have to face further prosecution under other federal laws.**

RIGHTS AND RESPONSIBILITIES

MEDICAID WARNING AND PENALTY - Only use Medical Assistance cards if you are eligible.

Every person convicted of "Medicaid Fraud" with a value of **$500** or more in money, services, or goods is guilty of a felony, and shall:

Pay back money, services or goods; or the value of those services or goods unlawfully received;
Be subject to a fine of no more than $10,000, imprisoned for no longer than five years, or both.

Every person convicted of "Medicaid Fraud" with a value of less than $500 in money, services or goods is guilty of a misdemeanor, and shall:

1. Pay back money, services or goods; or the value of those services or goods unlawfully received;
2. Be fined no more than $1,000 and imprisoned for no longer than three years or both.

READ BEFORE SIGNING:

I understand that it is important to give true information and if I do not, I am breaking the law.
I understand that I can be fined, imprisoned or have my benefits reduced for making false statements or for pretending to be another person.
I know I can be punished for not reporting changes that may affect my eligibility or benefit amount.
I understand that if I get more Food Supplement benefits than I should, all adult members of my household are liable for repaying the debt.
I know the Department can use the application against me in a court of law for fraud prosecution.
I know that failing to report or verify shelter, medical or dependent care expenses or child support payments is the same as saying I do not want a deduction for the expenses I did not verify or report.
I understand that the Department may check the information on this form to see if it is correct and may select my case for a spot check, such as for a Quality Control Review.
I agree to allow someone from the Department to visit me at home. I will help them get all needed proofs from any source.

- I understand by signing this application:
- I accept cash assistance and/or medical assistance.
- I agree that Medicare Part B will make payments directly to doctors and medical suppliers.
- I give the Department the right to seek payment from private or public health insurance and any liable third party. I understand that I must cooperate with the department in securing such payments. The Department may seek payment without legal action, as long as it does not keep more than the amount Medical Assistance paid.
- I give the Department the right to inspect, review and copy all medical records for services received through the Medical Assistance Program.

I understand that when a person is deceased who was at least 55 years old when receiving Medical Assistance the state may take money from the estate to repay payments made on behalf of that person. The program may take the money only if there is no surviving spouse, unmarried child younger than 21, or blind or disabled child (married or unmarried) of any age.

RIGHTS AND RESPONSIBILITIES

SIGNATURE SECTION

I understand that, as required by Maryland law, certain law enforcement agencies that investigate fraud can obtain information about my application, income, benefits and other documentation as part of their investigation. While access to my application and benefit information is normally limited (under Md. Code Ann. Human Resources Article § 1-201), these limits do not apply to these investigative agencies. Such agencies include the Department of Human Resources' Office of the Inspector General. I understand that I do not need to provide consent to these agencies in order for them to investigate any allegations of fraud against me. Any information found as a result of the investigation may be used against me if an allegation of fraud is prosecuted.

I have read or someone has read and explained the entire application to me. I swear or affirm under penalty of perjury, that all the information I gave is true, correct, and complete to the best of my ability, belief and knowledge. I received a copy of my rights and responsibilities. I authorize any person, partnership, corporation, association, or governmental agency that knows the facts about my eligibility to give that information to the Department. I also authorize the Department to contact any person, partnership, corporation, association, or governmental agency that has given proof of my eligibility for benefits. I certify, under penalty of perjury, that by signing my name below, all persons for whom I am applying are U.S. citizens, lawfully admitted immigrants or individuals in satisfactory immigration status.

Signature of Applicant/ Recipient		Date
Signature of Witness (If you Signed an X)		Date
Signature of Spouse (If Applicable)		Date
Signature of Authorized Representative (If Applicable)		Date
Signature of Case Manager		Date

I withdraw my application for: □ Cash Assistance □ Food Supplement Program □ Medical Assistance

Signature of Applicant, Recipient, Authorized Representative		Date

ASSIGNMENT OF SUPPORT RIGHTS FOR TEMPORARY CASH ASSISTANCE

- I assign to the State of Maryland all rights, titles, and interest in support that I may have for myself or for any person receiving TCA.
- This includes any overdue support that has not been collected for the time that I or any person received TCA assistance.
- I agree to have the child support agency collect any support owed to me and to keep up to the amount of TCA paid to me.
- I agree to send to the State of Maryland any support I receive. If I do not turn over this support, I will have to repay this amount to the State of Maryland. I may also be prosecuted for fraud.

When I am eligible for Medical Assistance:

- I assign all rights, title, and interest in medical support and health insurance payments I may have for myself or any person receiving Medical Assistance. This includes overdue medical support or health insurance payments that have not been collected.
- I agree to have the child support agency collect medical support payments owed to me and to keep up to the amount of Medical Assistance payments that were made for me.
- I agree to give the State of Maryland any medical support or health insurance payments I receive.
- I will cooperate to the best of my ability and knowledge with the child support agency while I am receiving TCA and Medical Assistance
- If I do not cooperate with the child support agency, I may lose all my benefits and my case may be closed

I HAVE READ THESE STATEMENTS OR SOMEONE READ THEM TO ME. I UNDERSTAND WHAT THEY MEAN. BY SIGNING MY NAME BELOW, I AGREE TO FOLLOW WHAT THEY SAY.

Signature	**Date**